THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

February 16, 2022

The Honorable Alejandro Mayorkas
Department of Homeland Security
Washington, D.C. 200528

Dear Secretary Mayorkas:

I write regarding the efforts of the Department of Homeland Security (DHS) to update its public charge regulation. As you know, the Department of Health and Human Services (HHS) has been consulting with DHS on the development of its Notice of Proposed Rulemaking (NPRM). This work is in furtherance of President Biden's Executive Order on *Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans* (EO 14012). EO 14012 directs the heads of federal agencies, including HHS, to review the public charge policy and identify agency actions to address concerns about the public charge provision's impact on the public health and recommend steps to reduce fear and confusion among impacted communities.[1] These are critical issues for ensuring that individuals and families are able to access HHS' programs and services. As requested, we are also providing information about two HHS benefit programs and whether their receipt is probative that an individual is likely to become a public charge.

This letter expresses HHS' general support for the public charge framework in the 1999 Interim Field Guidance and 1999 proposed rulemaking, under which the Immigration and Naturalization Service (INS) and then DHS operated until 2019. Under that framework, individuals are determined to be inadmissible on the public charge ground if they are likely to become "primarily dependent on the government for subsistence, as demonstrated in the totality of the circumstances by either (i) the receipt of public cash assistance for income maintenance or (ii) institutionalization for long-term care at government expense."[2] These policies were based in part on a letter from the then-Deputy Secretary of HHS that contrasted cash benefits for income maintenance, on which an individual could rely for basic subsistence, with non-cash benefits and services, which are supplemental benefits that do not fully provide for an individual's or family's basic subsistence needs and thus are insufficient to provide primary support absent additional

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[1] Exec. Order No. 14012: Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans, at Sec. 4, 86 Fed. Reg, 8377 (Feb 2, 2021) *available at* https://www.federalregister.gov/documents/2021/02/05/2021-02563/restoring-faith-in-our-legal-immigration-systems-and-strengthening-integration-and-inclusion-efforts (last visited Feb. 2, 2022).

[2] HHS recommends updating the terminology of "institutionalization for long-term care at government expense" to "long-term institutionalization at government expense" to better reflect the services covered by the public charge policies.

income.[3] HHS reaffirms and updates the analysis in that letter, including with respect to Medicaid.[4] Most recipients of non-cash federal health and human services benefit programs, such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and child care subsidies from the Child Care and Development Fund (CCDF), do not rely on income from cash assistance programs like Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). In calendar year 2018, over 90 percent of recipients of CCDF and Medicaid received no cash assistance. In fiscal year 2019, around 75 percent of SNAP recipients, received no cash assistance from TANF and SSI.[5] Medicaid, as a non-cash health coverage program, does not provide assistance to meet basic subsistence needs such as for food and housing, except in the limited circumstance of Medicaid-funded long-term institutionalization at government expense. With the exception of long-term institutionalization at government expense, receipt of Medicaid benefits is therefore not indicative of a person being or likely to become primarily dependent on the government for subsistence.

Indeed, developments since 1999 further reaffirm Medicaid's status as a supplemental benefit program that addresses health care needs. Congress has expanded Medicaid coverage, such that in many states individuals and families are eligible for Medicaid despite having income substantially above the HHS poverty guidelines.[6] Among working age adults without disabilities who participate in the Medicaid program, most are employed.[7] It would therefore be even more inappropriate today than it was in 1999 to treat receipt of Medicaid benefits (other than long-term institutionalization at government expense) as indicative of primary dependence on the government. Doing so, moreover, could have a significant negative public health impact. The 1999 HHS letter discussed the possibility of immigrant families and children declining to participate in important health care programs for which they are eligible due to confusion and fear related to public charge policies, known as a "chilling effect."[8] Recent evidence supports that concern, with research showing reductions in participation in health care programs due to

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[3] This letter was included in the record of the 1999 NPRM. *See* Letter from Kevin Thurm, Deputy Secretary of Health and Human Services, attached as an Appendix to "Inadmissibility on Public Charge Grounds; Proposed Rule and Notice," 64 Fed. Reg. 28676 (issued May 26, 1999), *available at* https://www.govinfo.gov/content/pkg/FR-1999-05-26/html/99-13188.htm at 2.

[4] Medicaid provides health coverage to nearly 25 percent of people living in the United States and is the largest single source of health coverage in the nation. *See* Center for Medicare & Medicaid Services, Medicaid & CHIP Enrollment Data Highlights (June 2021), available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html; CMS Fast Facts (issued Nov 2021), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts.

[5] U.S. Department of Agriculture (2020). *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2019*, Report No. SNAP-20-CHAR, Washington, D.C., available at: https://fns-prod.azureedge.net/sites/default/files/resource-files/Characteristics2019.pdf.

[6] *See* 87 Fed. Reg. 3315 for the 2022 HHS poverty guidelines.

[7] Among Medicaid beneficiaries ages 19-64 who are not on SSI, between 63 percent and 75 percent report that they are currently working. *See* Kaiser Family Foundation, *Work Among Medicaid Adults: Implications of Economic Downtown and Work Requirements* (February 11, 2021), available at https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-appendix-2/; Health Affairs, *The Dynamics of Medicaid Enrollment, Employment, and Beneficiary Health Status* (September 2019), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00066.

[8] Thurm letter at 2-3.

these issues.[9] And those public health implications have been highlighted by the COVID-19 pandemic and the important role that HHS health care programs like Medicaid have played in vaccination and treatment of COVID-19.

HHS also administers the TANF program, which provides states with funds that can be used for a variety of services including cash assistance payments. Unlike Medicaid, cash assistance programs under TANF have remained limited to families with few sources of other income and are much more frequently used as a primary source of subsistence. While receipt of cash assistance does not necessarily mean that an individual is primarily dependent on the government, unlike non-cash benefits, it is relevant to the determination. We, therefore, agree with INS's 1999 Field Guidance that receipt of cash assistance for income maintenance, in the totality of the circumstances, is evidence that an individual may be primarily dependent on the government for subsistence.

Finally, HHS recommends that DHS consider clarifications to its public-charge framework that would account for advancements over the last two decades in the way that care is provided to people with disabilities and in the laws that protect such individuals. Consistent with the 1999 framework, HHS recommends that DHS make clear that Medicaid-funded home and community-based services (HCBS) are not included in the public charge determination. Medicaid-funded HCBS help older adults and people with disabilities live, work, and fully participate in their communities, promoting employment[10] and decreasing reliance on costly government-funded institutional care. Unlike long-term institutional care, HCBS do not include payments for room and board, and therefore—unlike institutionalization—do not provide total care for basic needs or otherwise indicate that a person is primarily dependent on the government for subsistence.[11] Given the increased availability of HCBS over the last two decades due to a combination of new authorities passed by Congress[12] and states implementing the Supreme Court's decision in *Olmstead v. L.C.*,[13] many people who have in the past been institutionalized

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[9] Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options (Issue Brief No. HP-2021-26). Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2021, available at https://aspe.hhs.gov/reports/insurance-coverage-access-care-immigrants.

[10] *See* https://www.medicaid.gov/medicaid/long-term-services-supports/employment-initiatives/employment-hcbs/index.html (describing Medicaid HCBS supports for employment); *see also* https://www.macpac.gov/wp-content/uploads/2018/07/The-Role-of-Medicaid-in-Supporting-Employment.pdf.

[11] *See* Ctrs. for Medicare & Medicaid Servs., *Institutional Long Term Care*, *available at* https://www.medicaid.gov/medicaid/ltss/institutional/index.html; *see also* 42 C.F.R. § 435.700 *et seq.*

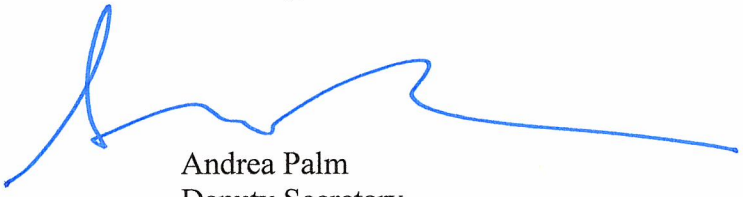
[12] Congress has greatly expanded access to HCBS since 1999 by establishing a number of new programs that reduce the need for long-term institutionalization, including the Money Follows the Person program and the Balancing Incentive Program, and new Medicaid state plan authorities, including Community First Choice under 1915(k) of the Social Security Act (42 U.S.C. § 1396n(k), and the HCBS State Plan Option under 42 U.S.C. 1915(i) of the Social Security Act (42 U.S.C. § 1396n(i)). Most recently, Congress provided increased funding to expand HCBS in the American Rescue Plan. As a result of the combination of these new HCBS programs and authorities and the Supreme Court's *Olmstead* decision in 1999, states have significantly expanded HCBS since that time. *See*, e.g., CMS Long Term Services and Supports Rebalancing Toolkit, available at https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.

[13] In June 1999, one month after the 1999 Interim Field Guidance was issued, the Supreme Court held in *Olmstead v. L.C.* that unjustified institutionalization is discrimination based on disability. 527 U.S. 581 (1999). The *Olmstead* decision held that public entities are required to provide community-based services to people with disabilities when certain requirements are met. *Id.* at 587.

are now living productive lives in their own homes and communities. Thus, HHS also recommends that DHS consider, in the totality of the circumstances, the availability and continuing growth of HCBS in determining the relevance of past or current institutionalization in predicting whether an individual is likely to become a public charge. In addition, as a federal agency charged with ensuring compliance with federal disability rights laws, HHS encourages DHS take into account legal developments in the application of Section 504 of the Rehabilitation Act since 1999.[14]

HHS appreciates DHS' collaborative efforts to ensure that the public charge NPRM reduces confusion and fear for impacted communities and minimizes its impact on public health. Please let me know if HHS can be of further assistance as you finalize these policies that are so critical to the nation.

Sincerely,



Andrea Palm
Deputy Secretary

[14] Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability. 24 U.S.C. § 794.